FY07 HEALTH PLAN DESCRIPTION FORM – PPO-H[1]		
	PPO-H (HSA eligible)	
	In-Network	**Out-of-Network**
Important Note: This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the Plan, which contains all terms, covenants and conditions of coverage. Your Plan may exclude coverage for certain treatments, diagnoses or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (e.g. Plans may require Pre-Treatment Authorization or use of specified providers or facilities). Consult the actual Summary Plan Description to determine the exact terms and conditions of coverage. Coinsurance % reflects the amount the Plan will pay.		
Part A: Type of Coverage		
1. Type of Plan	Preferred Provider Organization	
2. Out-of-Network Care Covered?[2]	Yes, but patient pays more for out-of-network care.	
3. Areas of Colorado where Plan is Available	Plan is available nationally.	
Part B: Summary of Benefits		
4. Plan Year Deductible **a) Single Coverage** **b) Family**	 $1,400 $2,800 The family deductible must be satisfied before benefits are paid for any individual family member. The in-network deductible may not be used to satisfy the out-of-network deductible.	 $2,800 $5,600 The family deductible must be satisfied before benefits are paid for any individual family member. The out-of-network deductible may not be used to satisfy the in-network deductible.
5. Out-of-Pocket maximum per Plan Year[3] **a) Single Coverage** **b) Family**	 $2,500 $5,000 The family out-of-pocket maximum must be satisfied before benefits are paid at 100% for any individual family member. The in-network out-of-pocket maximum may not be used to satisfy the out-of-network out-of-pocket maximum.	 $5,000 $10,000 The family out-of-pocket maximum must be satisfied before benefits are paid at 100% for any individual family member. The out-of-network out-of-pocket maximum may not be used to satisfy the in-network out-of-network maximum.
6. Lifetime Maximum	No lifetime maximum with 2 exceptions: a) surgical treatment of morbid obesity, if Medically Necessary, is covered up to a lifetime maximum of $7,500 including complications; b) Substance Abuse 60-day inpatient and 60-visit outpatient lifetime maximum.	
7. Covered Providers	Great-West Healthcare Preferred Provider Network, Pharmacy Services provided by Express Scripts® by arrangement with Great-West Healthcare.	All providers licensed or certified to provide covered benefits.
8. Medical Professional Services	85% after deductible	65% after deductible
9. Office Visits	85% after deductible	65% after deductible
10. Scheduled Preventive Care **a) Children** **b) Adults**	 85% not subject to deductible 85% not subject to deductible	 65% not subject to deductible 65% not subject to deductible
11. Maternity **a) Prenatal care** **b) Delivery & Inpatient well baby care** **c) Delivery professional services**	 85% after deductible 85% after deductible 85% after deductible	 65% after deductible 65% after deductible 65% after deductible

HEALTH PLAN DESCRIPTION FORM – PPO-H[1]		
	PPO-H (HSA eligible)	
	In-Network	**Out-of-Network**
12. Prescription Drugs **Level of coverage and restrictions of prescriptions** **a) Retail** **- Generic** **- Preferred** **- Non-Preferred**	85% after deductible (Plan Year deductible – see #4 above.)	65% after deductible (Plan Year deductible – see #4 above.)
b) Mail Order **- Generic** **- Preferred** **- Non-Preferred**	85% after deductible (Plan Year deductible – see #4 above.)	Not covered. (No mail order out-of-network benefit.)
c) Self-admin. Injectables disp. thru Pharmacy	85% after deductible (Plan Year deductible – see #4 above.)	65% after deductible (Plan Year deductible – see #4 above.)
d) Injectables admin. in office or OP facility	70% after deductible (Plan Year deductible – see #4 above.)	70% after deductible (Plan Year deductible – see #4 above.)
The Prescription Drug Program has been designed to encourage the use of generic medications. If a generic drug is available, but the preferred drug is dispensed (whether by your request or upon a physician specifying "Dispense As Written"), you are required to pay the applicable preferred copayment PLUS the difference in cost between the generic and preferred drug. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as preferred drugs.		
13. Inpatient Hospital	85% after deductible	65% after deductible
14. Outpatient / Ambulatory Surgery	85% after deductible	65% after deductible
15. Other services **a) Laboratory** **b) X-ray** **c) MRI / PET / CAT scans** **b) & c) subject to Pre-Treatment Authorization**	85% after deductible 85% after deductible 85% after deductible	65% after deductible 65% after deductible 65% after deductible
16. Emergency Care[4]	85% after deductible	65% after deductible
17. Ambulance **a) Ground** **b) Air**	85% after in-network deductible, maximum benefit $1,000 per trip. 85% after in-network deductible, maximum benefit $10,000 per trip.	
18. Urgent Care[4]	85% after deductible	65% after deductible
19. Biologically Based Mental Health[4] Care	85% after deductible	65% after deductible
20. Other Mental Health Care	Maximum 45 full/90 partial days inpatient services and 30 visits for out-patient services per Plan Year. Number of days and visits applies to both in and out-of network; combined with Substance Abuse.	
a) Inpatient care **b) Outpatient care**	85% after deductible 85% after deductible	65% after deductible 65% after deductible
21. Substance Abuse	Maximum 45 full/90 partial days for inpatient and 30 visits for outpatient per Plan Year. Number of days and visits applies to both in and out-of-network; combined with other Mental Health. Lifetime maximum 60 full days for inpatient and 60 visits for outpatient. Other Mental Health is not subject to the 60-day or 60-visit lifetime limit, but inpatient days and outpatient visits for such services do apply to and reduce the 60-day or 60-visit lifetime limit for Substance Abuse.	
a) Inpatient Rehab. **b) Outpatient**	85% after deductible 85% after deductible	65% after deductible 65% after deductible

HEALTH PLAN DESCRIPTION FORM – PPO-H[1]		
	PPO-H (HSA eligible)	
	In-Network	**Out-of-Network**
22. Physical, Occupational & Speech Therapy **a) Inpatient** **b) Outpatient**	 85% after deductible 85% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.	 65% after deductible 65% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.
23. Durable Medical Equipment **a) Inpatient** **b) Outpatient**	 85% after deductible 85% after deductible, maximum benefit of $3,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to $3,000 max, but expenses for such devices are applied to and reduce the $3,000 max.)	 65% after deductible 65% after deductible, maximum benefit of $3,000 per Plan Year. Maximum applies to both in and out-of-network. (Prosthetic devices are not subject to $3,000 max, but expenses for such devices are applied to and reduce the $3,000 max.)
24. Medical Supplies (including oxygen)	85% after deductible	65% after deductible
25. Oxygen **a) Inpatient** **b) Outpatient**	 Included in Hospital 85% after deductible	 Included in Hospital 65% after deductible
26. Transplants	85% after deductible	Not Applicable. (Transplants must be in-network)
27. Home Health Care ***subject to Pre-Treatment Authorization***	85% after deductible, 60 visits per Plan Year. Maximum includes in and out-of-network visits.	65% after deductible, 60 visits per Plan Year. Maximum includes in and out-of-network visits.
28. Hospice **a) Inpatient** **b) Outpatient**	 85% after deductible, 30 days per Plan Year. Number of days applies to both in and out-of-network. 85% after deductible, 91 days per Plan Year. Number of days applies to both in and out-of-network.	 65% after deductible, 30 days per Plan Year. Number of days applies to both in and out-of-network. 65% after deductible, 91 days per Plan Year. Number of days applies to both in and out-of-network.
29. Skilled Nursing Facility Care	85% after deductible, 30 days per Plan Year. Number of days applies to both in and out-of-network.	65% after deductible, 30 days per Plan Year. Number of days applies to both in and out-of-network.
30. Dental Care	Not covered	Not covered
31. Vision Care	85% after deductible for exam only, no benefit for hardware.	65% after deductible for exam only, no benefit for hardware.
32. Manual Manipulation-Chiropractic Care and Acupuncture	85% after deductible, maximum benefit $750 per Plan Year per benefit. Maximum applies to both in and out-of-network visits.	65% after deductible, maximum benefit $750 per Plan Year. Maximum applies to both in and out-of-network visits.
33. Significant Additional Covered Services **a) Hearing Aids** **b) Infertility**	 85% after deductible, limited to $500 every 3 years. Maximum applies to both in and out-of-network. 85% after deductible, maximum benefit $2,500 per Plan Year. Limit applies to both in and out-of-network.	 65% after deductible, limited to $500 every 3 years. Maximum applies to both in and out-of-network. 65% after deductible, maximum benefit $2,500 per Plan Year. Limit applies to both in and out-of-network.
Part C: Limitations and Exclusions		
34. Period During which Pre-Existing Conditions are not Covered	Not applicable. Plan does not impose limitation periods for pre-existing conditions.	
35. What Treatments & Conditions are excluded under this Policy?	See Summary Plan Description for list of exclusions	

HEALTH PLAN DESCRIPTION FORM – PPO-H[1]		
	PPO-H (HSA eligible)	
	In-Network	**Out-of-Network**
Part D: Using the Plan		
36. Does the enrollee have to obtain a referral for specialty care in most or all cases?	No	No
37. Is Pre-Treatment Authorization required for surgical procedures and hospital care (except in an Emergency)?	Yes, see Summary Plan Description for list of procedures.	Yes, see Summary Plan Description for list of procedures.
38. If the provider charges more for a covered service than the Plan normally pays, does the enrollee have to pay the difference?	No	Yes
39. What is the main customer service number?	1-888-ST8-OFCO-(1-888-788-6326)	
40. Whom do I write/call if I have a complaint or want to file a grievance?	Call the Great-West Customer Service Department at (1-888-788-6326)	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Submit Appeals form to: **Great-West Healthcare** Attention Appeals/Grievance 8525 E. Orchard Road, 4T3 Greenwood Village, Colorado 80111	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if is a short-term policy.	Policy Number: 179528 Self-funded large group.	

HEALTH PLAN DESCRIPTION FORM – PPO-H[1]		
	PPO-H (HSA eligible)	
	In-Network	Out-of-Network
43. Does the Plan have a binding arbitration clause?	No	
44. What is the cost of this Plan? **a) Employee Only** **b) Employee + Child(ren)** **c) Employee + Spouse** **d) Family**	Rates are available on the Benefits website www.colorado.gov/dpa/dhr/benefits.	

[1]PPO-H is a HSA qualified High Deductible Health Plan (HDHP) as described by federal law.

[2]Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your Plan may require you to use in order for you to get any coverage at all under the Plan, or that the Plan may encourage you to use because it pays more of your bill if you use network providers (i.e. go in-network) than if you don't (i.e. go out-of-network).

[3]Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health Plan, which may or may not include the deductible or copay, depending on the contract for that Plan

[4]Emergency Care means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Urgent care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a member's health.

[4]Biologically Based Mental Health means: autism, schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.